The SelectCare POS Plan

Summary of Benefits for the Employees and Retirees of the State of Vermont

What Does "POS" Mean?

- The "SelectCare POS Plan" is a "Point-of-Service" (POS) plan. In this plan, you decide whether or not to use a network doctor or hospital at the **"point of service"**, meaning, each time you use a medical service. When you use a network provider, the plan is similar to an HMO, with no annual deductible and small copay per visit.

It's Your Choice

- You get access to quality care at the lowest out-of-pocket costs available under your plan by having your care coordinated through your Primary Care Physician and by seeing network providers. You also get the **freedom to choose** providers who aren't part of the network. Your copays are lowest when you see participating providers, but you're still covered for visits to non-network providers at a higher cost share.

Important Medical Plan Features

- You may choose a Primary Care Physician (PCP) – your personal doctor -- to coordinate your care. As your needs change, you may change your Primary Care Physician for any reason.
- **Preventive care services** for every covered family member and paid at 100%.
- See a participating OB/GYN – **no referral** required.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**.

Drug Plan

- The program is administered by Express Scripts, Inc. The annual deductible is $25 per covered person per year. The plan covers 90% of the cost of generic drugs, 80% of the cost of preferred brand drugs and 60% of the cost for non-preferred brand drugs. For the 2014 Plan Year, the maximum out-of-pocket cost per individual per year is $775 (which includes the deductible). **40% copay drugs do not contribute to the maximum out of pocket limit.** At the local pharmacy, you show you drug plan card and pay your copay; the State is automatically billed for the balance of the cost. The drug plan also features a mail order option, with the convenience of direct home delivery for long-term maintenance drugs.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician (PCP) Office Visit such as:	**YOUR COST IS THE COPAY – WITH NO ANNUAL MEDICAL DEDUCTIBLE.**	**THE PLAN PAYS 70% AFTER THE ANNUAL MEDICAL DEDUCTIBLE.**
Preventive Care/Well Care:		
Periodic Physical Exams (Children and Adults)	Paid at 100%	70%
Routine Immunizations and Injections	Paid at 100%.	70%
Adult/Child Medical Care for Illness or Injury	$20 Copay per office visit	70%
Procedures performed in a Physician's Office	$20 Copay	70%
Routine Mammograms	Paid at 100%	Paid at 100%
Specialist Office Visits such as:		
Consultations and Referral Physician Services	$20 Copay per office visit	70%
Well Care (Includes Pap Test and PSAs)	Paid at 100%	70%
Procedures performed in Physician's office	$20 Copay per office visit	70%
Inpatient Hospital Services:		
Semi-Private Room and Board	$250 Copay per admission	70%
Physician Services		
Diagnostic/Therapeutic Lab and X-ray		***All inpatient hospital admissions require Precertification. Call the toll-free number on your ID Card.***
Drugs and Medication		
Operating and Recovery Room		
Radiation Therapy and Chemotherapy		
Anesthesia and Inhalation Therapy		
Inpatient Surgeon's Charges	Paid at 100%.	70%
Second Surgical Opinion	$20 Copay per office visit.	70%
Outpatient Facility Services including:		
Operating Room, Recovery Room, Procedure Room and Treatment Room including:	Paid at 100%.	70%
Physician Services		
Diagnostic/Therapeutic Lab and X-rays		
Anesthesia and Inhalation Therapy		
Outpatient Preadmission Testing		
Office Visit	Paid at 100%.	70%
Outpatient Facility	Paid at 100%.	70%
Laboratory and Radiology Services such as:		
MRIs, MRAs, CAT Scans and PET Scans	Paid at 100%.	70%
Other Laboratory and Radiology Services		
Short-Term Rehabilitative Therapy including Physical, Speech, Occupational and Chiropractic Therapies.	$20 Copay per office visit – **Maximum of 60 visits per year in aggregate.***	70% **Maximum of 60 visits per year in aggregate.***
Prescription Drugs		
For both Retail and Mail Order Drugs Combined:		
Annual Deductible (Separate from your medical deductible)	$25 per individual/$75 per family	Not Covered
Plan Pays	90% for generic drugs, 80% for preferred brand drugs, and 60% for non-preferred brand drugs	
Your 2013 Annual Maximum Copay, excluding deductible	$750 per person	
2013 Maximum Out-Of-Pocket expense per year	$775 per person ($750 maximum copays plus $25 annual deductible.) , then the plan pays 100% for the rest of the calendar year	
Emergency and Urgent Care Services at:		
Physician's Office	$20 Copay	If true emergency, benefits are the same as the in-network benefits. If not a true emergency, benefits are paid at 70%.
Emergency Room, Urgent Care or Outpatient Facility	$50 Copay per visit, (waived if admitted)	
Ambulance	Paid at 100%.	
Maternity Care Services		
Initial Office Visit to Confirm Pregnancy	$20 Copay	70%
All other office visits	Paid at 100%.	70%
Delivery		
Hospital Charges	$250 Copay per admission	70%
Physician Charges	Paid at 100%.	70%
Inpatient Services at Other Health Care Facilities including: Skilled Nursing, Rehabilitation and Sub-Acute Facilities	Paid at 100%.**60 days maximum per calendar year**	70%. **Precertification applies. 60 days maximum per calendar year**
Home Health Services	Paid at 100%.	70% ; **40 visits per calendar yr.**
Family Planning Services		
Office Visits (tests, counseling)	$20 Copay	70%
X-ray/lab if billed by separate facility	Paid at 100%.	70%
Vasectomy/Tubal Ligation (excludes reversals)		70% **Precertification applies**
Inpatient Facility	$250 per admission	70%
Outpatient Facility	Paid at 100%.	70%
Surgery in Physician's Office	$20 Copay	
Infertility Treatment – Up to $50,000/lifetime		
Office Visits (tests, counseling)	$20 Copay	Covered in-network only
X-ray/lab if billed by separate facility	Paid at 100%.	
Treatment/Surgery (includes In-vitro Fertilization, Artificial Insemination, GIFT and ZIFT) done at an inpatient or outpatient facility or physician's office.	Paid at 100%.	Covered in-network only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Substance Abuse Precertification Required		
Inpatient Mental Health	100%	70%
Inpatient Substance Abuse	100%	70%
Inpatient Substance Abuse Detoxification	100%	70%
Inpatient Substance Abuse Rehab Facility	100%	70%
Outpatient Mental Health	100%	70%
Marital/Family Counseling	100%	Not Covered
Outpatient Substance Abuse	100%	70%
Durable Medical Equipment	Paid at 100%.	70% **$700 Calendar year maximum**
External Prosthetic Appliances	Paid at 100%.	70% **$1,000 Calendar year maximum**
Vision Care	$100 every two calendar years, no deductible or coinsurance, routine exams and lenses.	
OTHER BENEFIT INFORMATION		
Annual Deductible Individual Family	None None	$500 $1,000
Annual Out-of-Pocket (OOP) Maximum Individual Family	None None	$2,000 plus deductible $6,000 plus deductible
Coinsurance	None	The plan pays 70% of eligible charges after the annual deductible is met. You pay 30% of the charges after the annual deductible is met.
Precertification (Inpatient, Outpatient, and MRI's)	Handled by your physician	Member must obtain approval
Lifetime Maximum	Unlimited	Unlimited

* Out-of-network treatment maximums are reduced by in-network services used.

If you use an In-NetworkProvider (In-Network Services):

- All services must be provided by or referred by your Primary Care Physician (PCP) in order to be covered except for: emergency services, routine care provided by a participating OB/GYN, and mental health and substance abuse services..

If you use a Out-of-Network Provider (Out-of-Network Services):

- All out-of-network hospital admissions, outpatient surgeries and MRI's must be precertified by the member. Precertification **is not required** for emergency admissions. To precertify, call the telephone number on the back of your ID card.
- Benefits which are not covered out-of-network are: Organ Transplants, Infertility Treatment and Prescription Drugs.
- Once the out-of-pocket maximum for Out-of-Network services is reached, the plan pays 100% of eligible charges for the remainder of the calendar year.